CMS 2006 New Freedom Initiative Conference
Administrator Mark McClellen Remarks
April 10, 2006

Welcome, everyone, to the Sixth CMS New Freedom Initiative Conference. We've come so far together in such a very short time.

I want to start by thanking you for all of the work you are doing on behalf of people with a disability, young and old, no matter who, no matter where, no matter what. Because of your efforts, millions of Americans have choices, have control over how they live. Because of your efforts, millions of Americans are contributing to their community, are having a higher quality of life, and better health. Because of your efforts, Medicare with its new benefits especially drug coverage and care coordination, Medicare can do much more for people with a disability, especially if they have other chronic conditions.

I also want to thank Josefina Carbonell and the entire team at AoA and the AAAs around the country. Josefina will talk more in a moment about how our partnerships for New Freedom and community based living are stronger and can do more than ever.

Because of all of your efforts, we are about to enter a new era of personal control, of New Freedom, in the Medicaid program. As I will talk about today, the major reforms in February's Deficit Reduction Act – funding for cash and counseling and home and community based services, new support for long-term care insurance, and especially, the Money Follows the Person initiative, the President's key proposal for New Freedom in Medicaid – these proposals amount to the potential for a "reset" in the way Medicaid long-term care services work. With a concerted effort, every state can rebalance its Medicaid program, just as so many of you have made happen in a growing number of states and programs around the country. With the tools we have now, it's time to end the institutional bias in Medicaid.

The unprecedented opportunity we now have to implement overdue Medicaid reforms comes from your work with Real Choice Systems Change, with Medicaid Infrastructure grants, with a range of programs in the President's New Freedom Initiative. Thanks to you, people with disabilities not only should have an *expectation* of choice and community life – they can have that choice.

But with this opportunity, we have new work to do. New work to ensure that Medicaid keeps pace with the people it serves.

We've done a lot already, in a limited period of time. Thanks to your efforts, we're empowering people to take control of their health and live their lives on their terms. Just a few statistics:

- In 1995, only 19 percent of Medicaid long term care dollars were spent on community-based care; in 2004 we spent 36 percent —almost twice the share.

- In 1995, 30 percent of Medicaid long-term care dollars went to community-based care for people with mental retardation or developmental disabilities; in 2004 the allocation had practically doubled.

- In 1995, Medicaid supported 17 percent of aged and disabled beneficiaries in the community; by 2004 the portion had grown to 25 percent.

Our effort to rebalance long-term care is achieving results. Between 2001 and 2004, we spent a total of $68.7 billion to support home and community-based waivers generally. More money has been spent in those four years than during the previous eight years combined ($56.6 billion). Over the same 4-year period, expenditures for related state plans supporting community living grew as well, from $5.25 billion to $7.95 billion. This growth represents a remarkable 51 percent increase.

So this is a lot of progress. It makes clear that, Though institutional care may still be the best option for many people with disabilities—and a lot of encouraging work is underway leading to better quality care in nursing homes—today, institutional care is one option in a range of many. Thanks to modern technology and new ideas about how support can be provided; thanks to the work of everyone at this conference today to expand Medicaid coverage for alternatives in long-term care, we know—*we know*—that Medicaid can do better.

We know that when we give beneficiaries and their caregivers the opportunity to decide how to get long-term care, we get higher beneficiary satisfaction and better outcomes.

We know that we reduce the escalating cost of health care this way as well. Between 1999 and 2002, the average nursing home payment rose13 percent. In contrast, that same average cost per participant in a home and community-based waiver rose 2.2 percent.

And we've learned more about how to do it effectively. For example, we've learned that a range of counseling and support alternatives can work, depending on the state and local circumstances. We've learned that rebalancing initiatives can be more effective when they account for certain one-time expenses, such as security deposits and essential household furnishings when they want to move out of an institution for an independent life in the community, it's a better investment for everyone. We know how to do this.

On the other hand, we still have a ways to go.

As much as 70 percent of Medicaid spending still goes to institutional care. Sixty-nine percent of this are long-term care services for aged individuals; 37 percent are individuals with a disability living in an institution. And despite all our progress to date, most people with a disability in Medicaid still do not have a choice about how they get their long-term care.

So we still have a ways to go. But I know, based on our substantial progress and the new law, I know we can get there. If you were designing Medicaid today, you'd want to make applicants go through the waiver process and jump through hoops for the nursing home-only benefit, and make community-based services the default setting. You'd want them to have the freedom to make a choice. Well, this should happen in every state, and let's use the new support from the Deficit Reduction Act to make it happen.

A week ago, we released a Medicaid Roadmap for Long-Term Care Reform. This roadmap outlines all of the new authorities and new funding we have as a result of the DRA to provide new support and momentum for your efforts.

This is the first of a number of guidances, templates best practice summaries, and other documents that we'll be producing in the weeks ahead, to make sure we are using the unprecedented new opportunities coming in 2007 as effectively as possible. I know you all are familiar with many of these, but I'd like to summarize them here to make sure everyone is, and that we use this conference as an embarkation point to using these new tools in a coordinated and effective and extensive way to get the most impact.

We can enhance **Money Follows the Person's** flexible financing for long-term services with the DRA's enhanced match rate. This will enable support to move with the person as his or her long-term care needs and preferences change.

The DRA creates a new state option and new funding for home and community-based care, without requiring either a waiver or beneficiaries to get institution-level care in order to take advantage of community services. We are very serious about this. We want these systems have a "default" assumption that the best placement for most individuals is in the community setting and we are providing states with the support and resources they need to transform long-term care.

The DRA provides new options for Cash and Counseling programs, to allow people with disabilities on Medicaid to manage their care and its cost and get support in doing so with greater flexibility and control. It's new federal help not only to reduce long-term care costs for people with a disability, but also to help them overcome some of the bumps in the road and give them much better, up-to-date benefits in the process.
There is new support for **home and community-based alternatives to psychiatric residential treatment facilities** for children.
Finally, to make sure states have support for planning for these reforms effectively as soon as possible, we are encouraging the use of this year's Real Choice Systems Change grants to get comprehensive state implementation plans in place. RCSC has been an instrumental program in developing the evidence that rebalancing can work, and how to do it successfully. In fact, as many of you know, this morning CMS announced new grants under **Real Choice Systems Change Grants for Community Living**.

Now as we enter this next phase of Medicaid long-term care benefits, it's time to move past pilots and demonstrations on a small scale to overall Medicaid redesign. In

particular, we invite you to submit proposals to make changes will result in effective and enduring improvements in community long-term support systems that can be implemented in conjunction with MFP or other home and community based reforms.

For example, this might include improved access to long-term care support services, comprehensive quality management, information technology, increased choice and control, and increased access to safe and affordable housing, in conjunction with a state Medicaid MFP proposal.

I've spent a lot of time talking about long-term care reforms, because now really is the time to make it happen. But you know that up to date, effective acute-care health insurance is also essential. The DRA includes a number of important provisions for making up to date health insurance available to more families and children, and to help them get coverage they can keep as they get a job or as their situation improves.

But I do want to mention some health insurance reforms that do provide important new opportunities.

First, the DRA also gives us the flexibility to expand health coverage for individuals with disabilities. In states that enact this reform, more families with disabled children will be able to purchase coverage and individuals with disabilities return to the workforce and get health care coverage when they are working. Second, for people who are dually eligible for Medicare and Medicaid, Medicare funding is also moving toward allowing more choice and control in the form of integrated benefits specifically tailored to the needs of people with a disability and multiple chronic illnesses or impairments.

Medicare Special Needs Plans or SNPs for dual eligible individuals are designed for high-cost, high-risk beneficiaries, and offer enormous potential if extended to Medicaid. SNPs are already being used on a large scale: there are over 540,000 dually-eligible people enrolled in Medicare Advantage plans. Forty Medicaid plans have already been approved to offer MA SNP contracts in 2006.

States like Massachusetts, Minnesota, New York and California have capitalized on providing integrated care and preventive benefits for dual-eligibles, people with HIV/AIDS, frail elderly people, and others. With more benefits focused on care coordination and prevention and the cost is lower overall, because payments aren't reduced when plans take steps to deliver better-coordinated care. Our MA payments are based on the health of the beneficiaries, using risk adjustment. This amounts to giving people with disability and chronic diseases more control over how Medicare benefits are provided on their behalf, and can be integrated with Medicaid.

Third, as you all know, for the first time ever, Medicare has a new prescription drug benefit. This benefit offers extra help for people with full Medicaid benefits, and also hundreds of thousands more people with a disability with limited benefits or low incomes.

We have had early implementation problems, especially in January when more than 20 million people started coverage at the same time. The problems disproportionately affected dual-eligible beneficiaries, particularly those who had joined or switched plans late in the month.

I want to be clear that we own these early implementation problems. They have been ours to solve, we have worked around the clock to solve them, and we are continuously improving key processes to work even more smoothly and effectively with providers, the drug plans, the states, and beneficiaries.

But the fact is, the people who are enrolled—that's more than 27 million as of our latest count—are getting their medicine.

As a result of this new drug benefit, people in minority communities, especially people with limited incomes, will gain.

Coverage—including for people with limited means—is truly comprehensive. All drug plans must provide beneficiaries with the highest treatment standards and the best of modern medicine. Medicare plan formularies generally cover an unusually broad range of drugs. Plans must provide access to all medically necessary drugs and they must serve people with special needs, including people living in nursing homes, people with mental health conditions, with HIV/AIDS, and other disabilities.

And the savings are substantial. For approximately 4 million minority Americans who have limited income, the coverage will have a zero premium, no deductible, and co-pays of only a few dollars per prescription or even less. *Consumers Union* found that seniors can increase savings to 60 to 70 percent or more on a broad range of drug plans by using generic drugs and by switching to brand-name drugs that work in a very similar way to the drug they are taking now.

People with Medicare and Medicaid have already been enrolled in a Medicare prescription drug plan, so their coverage was continuous. But other people who have limited means must opt in.

So, to make sure beneficiaries who qualify for the low-income subsidy do not miss out on the coverage, we are automatically enrolling beneficiaries in a drug plan who have signed up for the low-income subsidy but who have not chosen a plan on their own.

The group includes not only people who have applied for and been approved for extra help but also people who are enrolled in other federal assistance programs such as Supplemental Security Income and Medicare Savings Programs. This way, we ensure that they do not miss out on comprehensive, low-cost drug coverage.

CMS has already mailed letters to approximately 1 million people in this group. The letters let them know which Medicare prescription drug plan they will be enrolled in if

they take no action before April 30 and—unless they enroll on their own—their prescription drug coverage will begin on May 1.

But right now we need your help, especially in these last few weeks before the May 15 deadline.

We have increased support for our enrollment and education activities, including expanded servers on Medicare.gov. We are also maintaining high staffing levels of trained customer service representatives on 1-800-Medicare, to keep wait times to a minimum. We're handling hundreds of thousands of calls each week now, and we expect that may pick up considerably. Prescription coverage is a major step for improving the health of underserved Americans and we want them to take full advantage of extra help as soon as they can.

While much is going on in providing better, up to date benefits for people with Medicaid, and for people with Medicare, there is also new support for helping people plan and save for long-term care outside of these government insurance programs.

With the aging of the population, we cannot sustain Medicaid for the people who truly need it if the vast majority of people continue to depend on it first, rather than last, to pay for long-term care needs.

I know this may not be that popular to say, but it's a fact: In the years ahead, with rising health care costs and the aging of the Baby Boom, the only way, the only way that Medicaid will remain sustainable for those who really need it, to provide high-quality and up to date long-term care services, is if we find better ways to help people plan for their long-term care needs.

Now, AoA is our close partner in these efforts, and you're going to hear more about the new efforts we are undertaking together to get better planning and support for long-term care needs from Josefina in just a minute. But I want to mention a few issues here. This really is another urgent priority for all of us.

The DRA expands the **Long-Term Care Partnership Program**, which enables people to protect assets if they purchase LTC insurance policies. People who buy these limited policies don't end up on Medicaid. Beginning January 1, 2007, every state will be able to offer long-term care partnerships that will enable beneficiaries to pay for long term care and replace their assets and resources dollar-for-dollar with insurance payments. The **National Clearinghouse demonstration** will help individuals and their caregivers find out about the long-term support options other than Medicaid available to them. And, we are working to expand our education programs and resources to increase awareness about the need to plan for long-term care. We want to make sure that Americans know about better ways to prepare for long-term care.

We are working with the AoA and local agencies on aging on **Choices for Independence** initiatives, to expand funding support now being implemented in 43

states through Aging and Disability Resource Centers to help people avoid spending down to get Medicaid. I'm going to turn to Assistant Secretary Carbonell in just a moment to tell you more about all of these important new initiatives.

But first, I'd like to thank you again for being here. This is a really important time for people with a disability, a really important time for us to be together here. Now is the time for us to be aiming for nothing less than rebalancing the entire Medicaid program, so that everyone who depends on it can choose. To choose their providers. To choose to be in the community. To have the freedom to choose the life they want.

Rebalancing Medicaid is not only good policy because it leads to better health and lower costs per person and a greater ability for Medicaid to serve the people who need it. It's just the right thing to do. It's been a real privilege for me to work with many of you to get these demonstration programs implemented, and recently to get the MFP legislation enacted. Now, I'm looking forward to continuing to work with you on the tough work we have ahead to get Medicaid rebalanced. I know you, and with your energy, your commitment and all that you've achieved so far, I know we're going to find a way to make it happen. I know you will make the most of this conference over the next few days. And I know we'll look back on this time, on this conference, as when the next phase – really the next era – in Medicaid began.

Now I would like to take this opportunity to introduce the Assistant Secretary of the Administration on Aging, Josefina Carbonell.

Asst. Secretary Carbonell has been a tremendous friend and partner in bringing the highest quality services to the people of this nation. We've worked together on the Aging and Disability Resource Center initiative I mentioned earlier.

She has crossed the country multiple times to talk to people—in English and Spanish—about the importance of enrolling in the Medicare Prescription Drug benefit.

She has an extensive track record improving older Americans' health and enabling elderly individuals to maintain their independence and well-being in the community, where they overwhelmingly prefer to be—all the way back to the days when she was the President and CEO of one of the largest Hispanic geriatric health and human service organizations in the nation—the Little Havana Activities and Nutrition Centers in Dade County, Florida.

I invited Asst. Secretary Carbonell here today so she could provide you with additional details about her new long-term care initiative, *Choices for Independence*.

Welcome, Josefina.